Sexuality and Mental Illness

A small group approach

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The issue of sexuality and the mentally ill provokes an uneasy reaction in many people. The lay person possesses inaccurate notions, for instance, about the level of sex drive or the expression thereof. Public interest and anxiety was recently fuelled by the case of Jeanette, the mentally handicapped woman for whom sterilisation was requested.[1] Less understandable is the reaction of the more informed carers of the mentally ill. Being in such a position of responsibility raises a challenge, though the usual attitudes are of either ambivalence or denial. It was not then without some reservations that we organised a group for young people with psychotic conditions, with the aim of tackling sexual issues in relationships.

Social withdrawal, personality deterioration and reduced drive are described as features of chronic schizophrenia. The concept of an inability to gain pleasure from any activity is however challenged by Arieti.[2] Other authors have observed that sexual appetite is unimpaired.[3] Arieti also senses a change in the pattern of sexual expression over recent years so that exhibitionist behaviour is now more common than withdrawal. This is thought to reflect the more liberal ideas of today. Nevertheless it cannot be denied that the chronic psychotic experiences profound difficulties with relationships and the expression of sexual drive. Inappropriate and bizarre social behaviour makes the establishing of relationships difficult. There is a withdrawal from social contact and therefore reduced appetite for dating. In addition, the experience of a devastating psychosis in the late teens and early adult life occurs at a time when social and sexual behaviour would ordinarily be established. Delusions of a sexual nature may further undermine attempts to engage in normal behaviour. Drug effects may adversely affect sexual drive and functioning and lead to further confusion.

The patients' problems outlined above are compounded by the difficulties of life in an institution and by the opinions of the carers. The easiest and therefore commonest way of handling this situation is to ignore it. There may be a conscious denial that sexual drives exist or are a problem, though on many wards there is a tacit acceptance of some behaviour such as masturbation, provided it is not public. There is perhaps a fear that to broach the subject will be perceived as actively encouraging widespread promiscuity. Relatives will perhaps be concerned that the patients are 'protected'.

It is apparent, however, that patients are not generally in a state of blissful ignorance, though most sexual encounters will take place in the bushes rather than the wards. Sexual awareness there may be, but it is plain that information and education is lacking. Despite the inclusion of social skills training in most rehabilitation packages, sexual education is rarely a component.

One of the primary aims of our group therefore was that of education, and to approach the subject in an explicit though non-threatening manner. In order to make it acceptable to staff and patients it was called the 'Relationships Group'. Indeed, social aspects were addressed widely, as another target was to encourage more appropriate behaviour.

Group leaders. The group leaders consisted of three members of the rehabilitation team: a senior clinical psychologist, a psychiatric registrar and a staff nurse. The staff nurse had never been involved in running a group before and it was intended that the group would also provide training.

Selection of group members. We asked nine patients attending the Rehabilitation Day Unit if they would be interested in joining a closed group which would be looking at relationships. Deciding on a fairly large initial membership ensured that the group would survive if, as inevitably happened, patients were absent on any given week.

We were keen to include younger patients who were currently involved in a relationship or those who were beginning to experiment with dating. We avoided having current partners in the same group. Acutely disturbed patients were also excluded.

Description of group members. All nine patients approached agreed to attend the group. There were five men and four women with ages ranging from 24–44 years, the average age being 32 years. There were eight day-patients and one in-patient. Half of the day-patients lived with relatives and half lived alone in their own homes. Seven had been diagnosed as schizophrenic and the other two as manic depressive. All were of average or above average intelligence. Each member of the group had a chronic illness and was receiving medication. All patients knew the group leaders well.

A third of the group had no dating experience, a third had limited experience (short-term relationships with little physical involvement) and the others had been involved in a more intimate relationship.

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Six of the group attended all meetings, one member missed one and the other two attended twice. The reason for this poor attendance was an acute exacerbation of the illness in one case and the loss of a travel pass in the other.

The study

The leaders agreed that the group would meet weekly for six weeks. The duration of each meeting would be an hour. The groups would be held in the rehabilitation cottage which would provide a relaxed, non-institutional atmosphere. A highly structured group was planned, for two main reasons. Firstly, psychotic patients generally require an active style of group leadership because of their tendency to withdraw and become preoccupied with delusional thoughts. Secondly, the subject of relationships was judged to be potentially anxiety-provoking and an agenda for each week gave the group a clearly circumscribed area to discuss. The style of the leaders would be active, directive and supportive. Appreciating the poor concentration of our patients, we planned to enhance learning by using visual aids including posters, leaflets, diagrams and a video. To facilitate group discussion the members' ideas would be written on posters by a group leader. This would enable a group theme to develop and allow the slower members a chance to catch up on what others had said.

It took the leaders some time to agree on a title for the group. 'Sex Education' might deter some members and yet a less descriptive name such as 'Counselling Group' would not reflect the task of the group. The name 'Relationships Group' was chosen as it implied the content of the group without being threatening.

Three rules for the group were decided. Firstly, all matters discussed were confidential. Secondly, members should not volunteer information about other patients but rather talk about their own experiences. Thirdly, if they need to talk about personal matters outside group time they should contact the group leader.

Content of the group

The overall plan for the group was established and themes decided for each of the six groups, which are described below in more detail.

Week One The aims and rules of the group were introduced, and relationship difficulties were discussed. Topics introduced were 'Problems in making friends of the opposite sex' and 'Places to meet people'. As ideas were generated, they were written on posters, which were retained. One recurring theme was the stigma which patients experienced. They were uncertain whether they should reveal their background to new friends. Some patients displayed rather naive ideas about how to meet people but there was useful feedback from the rest of the group when particularly unlikely notions were put forward.

Week Two Two ideas were covered: 'Attraction in Relationships' and 'Stages of a Relationship'. Attention focused on what was appropriate behaviour over the course of a relationship, e.g. when should you hold hands, etc. Although initially predictable stereotypes were described, beneath this was a more thoughtful perception of the important elements of personal attraction.

Week Three Men and women met separately for this group with a therapist of the same sex. Sexual development and behaviour was explained using discussion, diagrams and leaflets. This also provided a chance for members to discuss topics which they found embarrassing in mixed company, for instance, masturbation.

Week Four There was further discussion of the perceived advantages and disadvantages of a close relationship, and the responsibilities this entailed.

Week Five A videotape presentation from the Health Education Department was used to explain contraception and family planning. Further leaflets and handouts were supplied.

Week Six For the first part of the meeting one of the group leaders gave a talk on the sexually transmitted diseases, including AIDS. This provoked considerable interest and discussion, revealing for the most part ignorance of the subject.

Finally, the group as a whole was reviewed, members completing a questionnaire to evaluate the usefulness of the programme. All patients rated the group as interesting, informative, comprehensive and simple to follow. They also noted that they had found it easy to state their opinions and particularly valued having both male and female group leaders.

Comments

Conducting a group for psychotic patients required a similar but tighter structure to that for neurotic patients. The cognitive, emotional and social difficulties of psychotic patients demanded a careful approach by group leaders. It was necessary to strike a balance so that time and space boundaries were observed, whilst supporting and facilitating group members to express their ideas.

It was often necessary to prompt patients to maintain punctual attendance. Each meeting was paced slowly, allowing time for the processing of new material. Often themes would reverberate on throughout the group and the leaders were called upon to integrate into the discussion what may have seemed to be inappropriate comments. Similarly, when delusional ideas with a sexual connotation appeared the leaders then had to function as interpreters, feeding back a more reality-orientated reply. For instance, a member remarked, "I thought I was going to marry a girl on the bus because she smiled at me". This was developed into the theme of "How can you tell if a girl is really interested in you?".

A general aim was to maintain a non-threatening atmosphere yet encourage withdrawn patients to speak. Direct questions may meet with a defensive silence; one way to overcome this was to use the third person in observations. For example "many people find it hard to start a conversation with a stranger", which invited group members to identify with the problem. Interpretations of the group process could cautiously be used sometimes to good effect. At a rather chaotic and disturbed moment for instance, it was

observed that laughter often conceals tension; the underlying anxiety was thus identified and the group could address the new task.

A hazard to be wary of is reinforcing silence by directing attention to a silent member of the group until he/she speaks and then transferring it to another non-speaking member. Any contribution, be it totally inappropriate or deluded, was acknowledged as adding to the life of the group, though some translation was sometimes necessary, and the leaders contrived their responses to encourage appropriate and sensible comments. It was hoped that patients recognised the different nature of the group, making it permissible to talk about things which confused them and about which staff too seemed ambivalent.

Successful rehabilitation of the mentally ill depends upon a comprehensive approach to their emotional and practical handicaps. The psychotic patient is vulnerable in many ways in the community and perhaps especially so with regard to sexual relationships. The impetus for this group arose because we felt that sexuality as an issue was not covered by our rehabilitation programme. The enthusiastic response of the majority of the group confirmed this belief. Indeed their openness at times surprised and encouraged us.

We now hope to incorporate similar groups into the rehabilitation programme on a regular basis. Some aspects we felt were of critical importance in the design. Firstly, adequate preparation of staff, patients and relatives, when appropriate, to identify and forestall resistance and opposition. Secondly, openness and frankness in the leaders to create an accepting and comfortable group atmosphere. This was facilitated in our group as two of the leaders had previous psychosexual counselling experience, but this is not absolutely necessary. Thirdly, a highly structured and directive approach is essential to keep the group going.

Finally, we hope our experiences will be of interest and would encourage others to consider tackling this difficult area.

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REFERENCES

[1] CHAKRABORTI, D. (1987) Sterilisation and the mentally handicapped. *British Medical Journal*, **294**, 794.

[2] ARIETI, S. (1974) *Interpretation of Schizophrenia*. London: Crosby Lockwood Staples. p. 46.

[3] SMALL, I. & SMALL, J. (1976) Sexual behaviour and mental illness. In *The Sexual Experience* (eds. B. J. Sadock, H. I. Kaplan and A. M. Freedman). Baltimore: Williams & Wilkins.

Conference Reports

The Tavistock Clinic Symposium on 'The Anxiety of Beginnings'

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The trouble with conferences is that you spend four-fifths of the time finding out whom you would like to know better and then, all too soon, these fascinating, sympathetic or otherwise interesting people have flown away, perhaps to be corresponded with or, in the manner or David Lodge's novel *Small World,* met once more on the conference circuit. The organisers of the first Tavistock Clinic Symposium, an invited gathering of 90 experts from Europe, North and South America and Australia, are to be congratulated on providing a structure that both stimulated and permitted a sufficient satisfying of professional curiosity. Careful attention to time-boundaries in the presentations (one would expect nothing less in this analytic Mecca!), good food and an hour and a half for lunch provided a felicitous background for serious consideration of the conference's theme: *The Anxiety of Beginnings*.

Four plenary presentations by our hosts introduced the principal topics which were further explored in parallel sessions where 34 papers were read; a conference publication is planned. This account reflects my track through the three days. Isca Wittenberg delineated the concerns of the novice therapist, the supervisor and the institution; she pointed to the importance of being open to new experience and of perceiving with a fresh eye when the inherent uncertainty of the therapy hour and the consequent threat to self-esteem through being in a state of ignorance push all three parties in the opposite direction of, in my words, hackneyed formulation and false certitude. She valued having a sense of wonder, developing confidence in one's own intuition and the institution being like a good parent who supports but does not stifle initiative.

To engage in therapy is to open oneself to disturbing